STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 21, 22, 23, & 24, 2011 Facility number: 000038 Provider number: 155095 AIM number: 100274830 Survey team: Rick Blain, RN TC Sue Brooker, RD Christine Fodrea, RN Timothy Long, RN Angela Strass, RN Julie Wagoner, RN Census bed type: SNF/NF: 146 SNF: 27 Total: 173 Census payor type: Medicare: 32 Medicaid: 92 Other: 49 Total: 173 Sample: 26 These deficiencies also reflect State findings in accordance with 410 IAC 16.2	F0000	The ceation and submission of this Plan of Corrction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation.Based on past survey history and no harm identified to any resident; this facility respectfully requests a desk review in lieu of a post-survey on or after March 18, 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed 3/3/11 by Jennie Bartelt, RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0272 SS=D	Based on record review and interview, the facility failed to assess a decline in bowel continence for 3 of 9 residents reviewed for incontinence in a sample of 26 . (Residents #60, 67, and 82) Finding includes: During the initial tour of the facility, conducted on 02/21/11 between 10:15 A.M. - 11:00 A.M., LPN #6 indicated Resident #60, 67, and 82 were all incontinent and required extensive staff assistance for hygiene and toileting needs. She indicated Residents #60 and #82 were toileted and Resident #67 was usually placed on a bedpan. 1. The clinical record for Resident #60 was reviewed on 02/23/11 at 10:07 A.M. The most recent full MDS (Minimum Data Set) assessment, completed on 06/10/10, indicated the resident was usually continent of her bowels. However,	F0272	F272 COMPREHENSIVE ASSESSMENTSIt is the practice of this provider to ensure a comprehensive, accurate, standardized reproducible assessment is conducted initially and periodically for each resident's fuctional capacity. However; based on the alleged deficient practice- the following has been implemented:What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #60 A bowel assessment has been completed for this residentResident #67 A bowel assessment has been completed for this residentResident #82 A bowel assessment has been completed for this residentHow will you identify other residents having the potetial to be affected by the same deficient practice and what corrective actio will be taken:No other residents were foud to have been affected by the alleged deficient practiceResidents experiencing a change in bowel continence have the potential to be affected by the alleged deficient practiceThe MDS Department will notify the Unit Manager of residents with a change in bowel continence per completion of the MDSThe Unit Manager/Designee will complete a bowel assessment to assist in identifying the causative factor of the change in continenceThe	03/18/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the most recent quarterly MDS assessment, completed on 11/30/10, indicated the resident had declined and was now frequently incontinent of her bowels. 2. The clinical record for Resident #67 was reviewed on 02/22/11 at 9:15 A.M. The most recent full MDS assessment, completed on 10/13/10, indicated the resident was frequently incontinent of her bowels. However, the most recent MDS review, completed on 01/10/11 indicated the resident had declined and was now totally incontinent of her bowels. 3. The clinical record for Resident #82 was reviewed on 02/21/11 at 2:20 P.M. The most recent full MDS assessment, completed on 08/18/10, indicated the resident was usually incontinent of her bowels. However, the most recent MDS review assessment, completed on 02/04/11 indicated the resident had declined and was now frequently		bowel assessment will be reviewed by the IDT at which time a note will be written and the careplan updated with any identified changesThe MDS Department and Nurse Management have been educated on this process. Education includes but is not limited to MDS notifying the Unit Manager of change in bowel continence, completion of the bowel assessment, appropriate documentation in the IDT note and updating the individual plan of careEducation provided March 17, 2011 by the Director of Nursing ServicesThe DNS/ADNS is responsible for oversight to ensure complianceWhat measures will be put into place or what systemic changes you will make to ensure that the deficient practice dows not recur:No other residents were foud to have been affected by the alleged deficient practiceResidents experiencing a change in bowel continence have the potential to be affected by the alleged deficient practiceThe MDS Department will notify the Unit Manager of residents with a change in bowel continence per completion of the MDSThe Unit Manager/Designee will complete a bowel assessment to assist in identifying the causative factor of the change in continenceThe bowel assessment will be reviewed by the IDT at which time a note will be written and the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incontinent of her bowels. There was no bowel incontinence assessment indicated in the records for Resident #60, 67, or 82. Interview with the Director of Nursing, on 02/24/11 at 10:30 A.M., indicated the facility had no policy to assess bowel incontinence and no assessment information could be located for any of the 3 residents. 3.1-31(a)		careplan updated with any identified changesThe MDS Department and Nurse Management have been educated on this process. Education includes but is not limited to MDS notifying the Unit Manager of change in bowel continence, completion of the bowel assessment, appropriate documentation in the IDT note and updating the individual plan of careEducation provided March 17, 2011 by the Director of Nursing ServicesThe DNS/ADNS is responsible for oversight to ensure complianceHow the corrective action(s) will be monitored to ensure the deficient practice will not recur:A CQI monitoring tool titled "Bowel Elimination" will be utilized every week x 4, monthly x 3 and quarterly thereafterData will be submitted to the CQI committee. If threshold is not met, an action pan will be developedNon-compliance with facility procedure may result in disciplinary action up to and including termination Completion Date: March 18, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	Based on record review and interview, the facility failed to implement an individualized care plan regarding toileting to address bladder incontinence for 2 of 9 residents reviewed for incontinence in a sample of 26. (Residents #174 and 60) Findings include: 1. The closed clinical record for Resident #174 was reviewed on 02/23/11 at 1:45 P.M. The resident had been admitted to the facility on 10/15/10. Diagnoses included, but were not limited to, end stage renal disease, hypertension, and chronic obstructive respiratory disease. The initial Minimum Data Set (MDS) assessment, completed on 10/28/10, indicated the resident was mildly cognitively impaired, required extensive staff assistance for hygiene and toileting needs, and was always incontinent of his bladder.	F0279	F279 DEVELOP COMPREHENSIVE CARE PLANIt is the practice of this provider to ensure the results of the assessment are used to develop, review and revise the resident's comprehensive plan of care. However; based on the alleged deficient practice- the following has been implemented:What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #174 This resident no longer resides at this facilityResident #60 The resident's voiding diary has been reviewed. The resident is on an individualized toileting program (Program #1) and the plan of care has been updated to reflect the change.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:No other residents were found to have been affected by the alleged deficient practiceResidents with urinary incontinence have the potential to be affected by the alleged deficient practiceUpon completion of the 3-day voiding diary the Restorative Nurse reviews continent and incontinent episodes and assigns the appropriate Toileting Program based on the diary results. The careplan is updated and individualized using the identified	03/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The bladder incontinence assessment, completed on 10/15/10, the day the resident was admitted, indicated the resident was always incontinent, was able to comprehend and follow simple instructions, could verbalize his needs, and was able to maintain a sitting position. The assessment indicated the resident could not identify the urge to urinate, could not locate or manage toileting himself or adjusting his clothes related to toileting, or utilize a call light. The resident's fistula for dialysis treatments was indicated as a contributing factor to the resident's incontinence, and a history of bladder incontinence was indicated on the assessment. There were no other assessment factors indicated on the assessment form. The assessment concluded the resident was not mentally or physically aware of the need to void and able to utilize the toilet and could not resist the urge to void.		appropriate Toileting ProgramThe Restorative Nurse has been re-educated on this provider's Toileting Programs for bladder incontinence. Education includes but is not limited to assessing the 3-day voiding diary including identifying patterns, assigning the appropriate Toileting Program and individualizing/updating the plan of care.Education provided March 17, 2011 by the Director of Nursing ServicesThe facility toileting program has been modified to ensure there is not an extended period of time between toileting opportunities.The modified toileting program allows that residents appropriate for Toileting Plan #2 will be toileted before or after meals using the following guideline:1. Residents are toileted upon rising in the A.M.2. Residents residing in an "even" numbered room are toileted before each meal3. Residents residing in an "odd" numbered room are toileted after each meal.4. Residents are toileted at HS5. Residents are checked every 2 hours through the night.The Modified Toileting Program Education will be provided to nursing staff through March 25, 2011 by the Director of Nursing Services/DesigneeThe DNS/ADNS is responsible for oversight to ensure compliance.What measures will be put into place or what systemic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A 3 day voiding pattern was completed on 10/16/10 - 10/18/10 and again on 11/20/10 - 11/22/10. Both patterning records indicated the resident was able to void correctly in the toilet several times during the day, with at least 3 times noted between 7:00 A.M. - 12:00 P.M. However, the resident was placed on toileting program #2, which is a plan to toilet the resident upon rising, before or after meals, and at bedtime and to check the resident for incontinence throughout the sleeping hours. Thus the resident could potentially be toileting upon rising, before breakfast, and not again till after lunch, approximately 6 hours later and still satisfy the boundaries of the toileting plan. There was no individualized plan to assist the resident maintain as much bladder continence as was possible. Interview with MDS nurse, LPN #5, and the Director of Nursing, on		changes you will make to ensure that the deficient practice does not recur:Upon completion of the 3-day voiding diary the Restorative Nurse reviews continent and incontinent episodes and assigns the appropriate Toileting Program based on the diary results. The careplan is updated and individualized using the identified appropriate Toileting ProgramThe Restorative Nurse has been re-educated on this provider's Toileting Programs for bladder incontinence. Education includes but is not limited to assessing the 3-day voiding diary including identifying patterns, assigning the appropriate Toileting Program and individualizing/updating the plan of care.Education provided March 17, 2011 by the Director of Nursing ServicesThe DNS/ADNS is responsible for oversight to ensure compliance.The facility toileting program has been modified to ensure there is not an extended period of time between toileting opportunities.The modified toileting program allows that residents appropriate for Toileting Plan #2 will be toileted before or after meals using the following guideline:1. Residents are toileted upon rising in the A.M.2. Residents residing in an "even" numbered room are toileted before each meal3. Residents residing in an "odd" numbered room are toileted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	02/24/11 at 10:00 A.M. indicated in their opinion, Resident #174 did not display any voiding pattern so the Toileting Plan #2 was adequate. LPN #5 indicated on a 60 day Medicare assessment, Resident #174's incontinence improved prior to his discharge from the facility so the facility's plan must have worked. There was no response when asked how a voiding pattern indicating a resident voided consistently 3 times between breakfast and lunch and a plan that could potentially provide no toileting opportunities was individualized to meet the resident's needs and assist the resident to attain and/or maintain the highest level of bladder continency possible. 2. During the initial tour of the facility, completed on 02/21/11 between 10:15 A.M. - 11:00 A.M., MDS nurse, LPN #6 indicated Resident #60 was confused, incontinent, required extensive staff		after each meal.4. Residents are toileted at HS5. Residents are checked every 2 hours through the night.The Modified Toileting Program Education will be provided to nursing staff through March 25, 2011 by the Director of Nursing Services/DesigneeThe DNS/ADNS is responsible for oversight to ensure compliance.How the corrective action(s) will be monitored to ensure the deficient practice will not recur:A CQI monitoring tool titled "Bladder Program" will be utilized every week x 4, monthly x 3 and quarterly thereafterData will be submitted to the CQI committee. If threshold is not met, an action plan will be developedNon-compiance with faciity procedure may result in disciplinary action up to and including termination Completion Date: March 25, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assistance for hygiene needs, and was on toileting plan #2. The clinical record for Resident #60 was reviewed on 02/23/11 at 10:07 A.M. The resident was admitted to the facility on 02/02/09 with diagnoses, including but not limited to, dementia, anxiety, and atrial fibrillation. The most recent full MDS assessment, completed on 06/10/10, indicated the resident was totally continent of her bladder, required extensive staff assistance for hygiene needs, and was not cognitively impaired. However, the most recent quarterly MDS review, completed on 11/30/10, indicated the resident was now frequently incontinent of her bladder. A quarterly MDS review, completed on 09/24/10, indicated the resident was totally incontinent of her bladder. A bladder continence assessment			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	form, completed on 09/18/10, indicated the resident was marked as both frequently and totally incontinent of her bladder, could comprehend and follow instructions, verbalize her needs, utilize a call light, and maintain a sitting position. The resident was assessed as not being able to identify the urge to urinate, could not manage the toilet or her clothing needs to toilet herself. The resident was listed as having a left total knee surgery and required the use of a stool extender, and had the following contributing factors: cerebral vascular accident, congestive heart failure, and diuretic use. A history of bladder incontinence was marked even though the previous assessment in June 2010 indicated the resident was continent of her bladder. The assessment concluded the resident was not mentally or physically aware of her need to void or utilize the toilet and could not resist the need to void.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A 3 day voiding pattern, completed from 09/08/10 - 09/10/10 indicated the resident was consistently wet but also voided at 5:00 A.M., 9:00 A.M., 11:00 A.M. - 12:00 P.M., 3:00 P.M. - 4:00 P.M., and 7:00 - 8:00 P.M during the non-sleeping hours. However, the resident was placed on toileting plan #2, which did not address the resident's voiding pattern and was not individualized to meet her toileting needs.

Interview with LPN #5 and the Director of Nursing, on 02/25/11 at 10:00 A.M., indicated they did not feel there was any voiding pattern for Resident #60 and they felt toileting plan #2 was adequate to meet the resident's needs.

Review of the facility's policy and procedure, titled, "Bladder Program," dated 03/10 and provided by the Director of Nursing on 02/24/11 at 9:10 A.M. indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155095	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PARK	2001 HOBSON ROAD FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the following: "...if a resident is totally incontinent and unable to be placed on a toilet or bedpan, the resident should be checked and changed every two hours, if a voiding pattern can be determined, develop an individualized resident specific program, update the care plan and resident care records/assignment sheet, if a voiding pattern cannot be determined, resident should be toileted upon rising, before and after meals, and at bedtime...." There was no procedure to place residents on a plan such as toileting plan #2 which allowed the potential to not provide toileting between meals if a resident was toileted prior to one meal and not until after the following meal. 3.1-35(a)			